PRINTED: 05/03/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DA	ΓΕ SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COM	1PLETED
		15G593	A. BUILDING B. WING		03/	15/2013
		_		ADDRESS, CITY, STATE, ZIF	P CODE	
NAME OF F	PROVIDER OR SUPPLIEI	R		2ND PL E		
	DIANA INC		НОВАГ	RT, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	E APPROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
W000000						
		or the pre-determined full	W000000			
	recertification at	nd state licensure survey.				
	Dates of Survey	y: February 19, 20, 21,				
		March 4, 5, 8 and 15, 2013				
	, , , , , , ,	,				
	Facility number					
	Provider number	r: 15G593				
	AIM number: 1	00245570				
	Surveyor: Chris	stine Colon, Medical				
	Surveyor III/QM					
	The following for	ederal deficiencies also				
	reflect state find	ings in accordance with				
	460 IAC 9.					
	Ouality review o	completed April 1, 2013				
		n, Medical Surveyor III.				
	by Don'y Walton	i, ividaicai bai veyoi iii.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED	
		15G593	B. WING	ING		03/15/2013	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			2ND PL E		
 REM-INF	DIANA INC				RT, IN 46342		
					1, 11, 100 12		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL		REFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
W000104		R LSC IDENTIFYING INFORMATION)		TAG	Berielekery	DATE	
VV00010 4	483.410(a)(1) GOVERNING B	ODY					
		ody must exercise general					
		and operating direction over					
	the facility.						
	Based on observ	vation and interview, the	W000	0104	The current policy for the facili	ty 04/13/2013	
	governing body	failed for 8 of 8 clients			is to maintain the health and		
	(clients #1, #2,	#3, #4, #5, #6, #7 and #8)			safety of the clients at all times	I	
	living at the gro	oup home, to supply			The facility is responsible and provide toilet paper and paper		
	-	paper products.			towels for each bathroom and		
		r-r-r			all the clients that live in the		
	Findings includ	۵٠			home. The Program Director will	vill	
	Tilldings illeidd	C.			retrain the Home Manager on		
		. 1 . 1			making sure that all supplies a		
	An evening observation was conducted on				in the home. The Home Mana will retrain the staff to make su	-	
		00 P.M. until 7:15 P.M			all supplies are restocked in a		
		lient #8 entered the			the bathrooms of the home. The		
		ed off the living room area			Home manager will check the		
	of clients #1, #2	2, #3, #4, #5, #6, #7 and			house weekly to make sure		
	#8's home. Wh	en client #8 exited his			supplies are in the home and i		
	hands were wet	and he wiped his wet			for any reason they are not the Home Manager will replace the		
	hands on his pa	nt legs. At 5:45 P.M.,			immediately. The Program	5111	
	client #2 entere	d the bathroom located off			Director will check the house		
	the living room	. When client #2 exited			monthly to make sure that all t	he	
		is hands were wet. At			supplies are in the home for th		
	5:50 P.M., the h	oathroom was observed			clients and staff use.Responsi	ble	
	· ·	aper holder, no toilet paper			Party: Area Director		
	_	or paper towels for the					
		5:53 P.M., the bathroom					
		kitchen was observed with					
	no tonet paper i	nolder and no toilet paper.					
	A	ide de a Directa Const					
		ith the Direct Support					
	,	SP) #4 was conducted on					
		P.M DSP #4 indicated					
	the toilet paper	holders needed to be					

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Event ID: A5FX11

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	of Correction identification number: 15G593	(X2) MULTIPLE CC A. BUILDING B. WING	00		LETED 5/2013
	PROVIDER OR SUPPLIER DIANA INC	3142 62	ADDRESS, CITY, STATE, ZII 2ND PL E RT, IN 46342	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	replaced. DSP #4 further indicated there should be toilet paper and paper towels available for the clients' use.				
	An interview with the Program Director (PD) was conducted on 3/8/13 at 1:30 P.M. The PD indicated there should be toilet paper holders, toilet paper and paper towels available at all times for clients #1, #2, #3, #4, #5, #6, #7 and #8's use. 9-3-1(a)				

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Event ID: A5FX11

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE :	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G593	B. WIN			03/15/	2013
			D. (VII.)	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1	2ND PL E		
REM-IND	DIANA INC				RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000125	The facility must exclients. Therefore and encourage in their rights as clie citizens of the Unright to file complay process. Based on observation interview, the fast sampled clients (to provide assistating to provide assistation to provide assistating to provide assistation to provide assistatio	evation was conducted at on 2/19/13 from 5:45 A.M. During the entire heating/cooling ed in the hallway leading drooms had a clear plastic the thermostat. ervation was conducted at on 2/19/13 from 5:00 P.M. During the entire heating/cooling ed in the hallway leading drooms had a clear plastic the thermostat. on was conducted at the	W0	00125	The facility is committed to maintaining the rights of all the clients in which the home they live. All employees are trained the client's rights upon hire and annually. The plastic cover wa removed from the theromstates the client can have free access the heating and cooling system. The Program Director Home Manager will be retrained by the Area Director that the clients should have access to heat and cooling system in the home. The staff will be retrain by the Program Director on the clients rights and specifically the need to access the heating and cooling of their home. The Home manager will check on a daily and weekly basis to make sure the client have full access the heating and cooling system their home. The Program Director will check monthly to make sur that the clients have access to heating and cooling system in their home. Responsible Party: Area Director	on d s s s s o and e d the e ir e e d e e s o f n in e t t t t t t t t t t t t t t t t t t	04/13/2013
		on was conducted at the 2/26/13 from 9:45 A.M.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED
		15G593	A. BUI B. WIN			03/15/2013
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			2ND PL E	
DEM INIT	DIANA INC			1	T, IN 46342	
				HODAIN	11, 111 40042	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	until 12:30 P.M.	During the entire				
	observation, the	heating/cooling				
	thermostat located in the hallway leading					
	to the clients' bedrooms had a clear plastic					
	locked box over the thermostat.					
	An interview wi	th Direct Support				
	Professional (DSP) #4 was conducted at					
	the group home on 2/19/13 at 5:45 P.M.					
		d the heating/cooling				
	thermostat was I	ocked at all times.				
	A review of clie	nt #1's record was				
	conducted at the	facility's administrative				
	office on 2/22/13	3 at 11:30 A.M. The				
	review failed to	indicate the need for the				
		ooling thermostat to be				
	restricted for clie	_				
	lestricted for en	m = m + 1.				
	A raviany of alia	nt #2's record was				
		facility's administrative				
		3 at 11:55 A.M. The				
	review failed to	indicate the need for the				
	home heating/co	ooling thermostat to be				
	restricted for clie	ent #2.				
	A review of clies	nt #3's record was				
	conducted at the	facility's administrative				
		3 at 1:55 P.M. The				
		indicate the need for the				
	1	ooling thermostat to be				
	restricted for clie	ent #3.				
	A review of clie	nt #4's record was				

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	of correction (X1) provider/supplier/clia (DENTIFICATION NUMBER: 15G593	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 03/	TE SURVEY MPLETED 15/2013
	PROVIDER OR SUPPLIER	3142 62	ADDRESS, CITY, STATE, ZIP 2ND PL E RT, IN 46342	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
TAG	conducted at the facility's administrative office on 2/22/13 at 1:24 P.M. The review failed to indicate the need for the home heating/cooling thermostat to be restricted for client #4. An interview with the Program Director (PD) was conducted on 3/8/13 at 1:30 P.M. The PD stated, "The thermostat should not be locked." 9-3-2(a)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	

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Facility ID: 001107

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	LIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETE	ED
		15G593	B. WIN			03/15/20 ⁻	13
			P. (VII)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				2ND PL E		
	DIANA INC				RT, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		OMPLETION
		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
TAG W000225	483.440(c)(3)(v) INDIVIDUAL PRO The comprehensi must include, as a Based on observe interview, the fact vocational needs requiring vocation #1, #2, #3 and #4 Finding include: Client #3 was obt on 2/20/13 from P.M. During the in the living roor No alternative dat to be provided. Client #3 was obt on 2/22/13 from P.M. During the in the living roor No alternative dat to be provided. Client #3 was obt on 2/22/13 from P.M. During the in the living roor No alternative dat to be provided. Client #3 was obt on 2/26/13 from A.M. During the in the living roor	ve functional assessment applicable, vocational skills. ation, record review and cility failed to assess the of 4 of 4 sampled clients onal assessments (clients 4).	W0	TAG 00225	The facility currently does a series of assessments to include the needs and ability of the client. The PD is trained the an assessment is done upon admission and annually of the client to determine skills, progress and areas that need be improved. Client #1, 2,3 ar will have an assessment completed on them in addition all the other clients who live in home. The Program Director where the process by the Area Director. Accopy of the assessment will be maintained in the home and set to other outside agencies such Day Program for documentati and support of the client during work and activities. Periodicall assessments can be amended based upon the need for change the client or additional support. The Program Director will retrate the Day Program Manager on assessments and how to use them for the client as a support tool.\Responsible Party: Area Director	f at to to the ill at A as on B y large in the	4/13/2013
		d was reviewed on A.M. A review of the					

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	OF CORRECTION	CTION IDENTIFICATION NUMBER:		(x2) MULTIPLE CONSTRUCTION A. BUILDING 00			SURVEY ETED
		15G593	A. BUII B. WIN			03/15/	/2013
			D. WIIV		DDRESS, CITY, STATE, ZIP CODE	l	
NAME OF F	PROVIDER OR SUPPLIER			3142 62	ND PL E		
REM-IND	DIANA INC			HOBAR	T, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		iled to indicate client #1's					
	vocational needs	and abilities had been					
	assessed.						
		d was reviewed on					
		A.M. A review of the					
		iled to indicate client #2's					
	assessed.	and abilities had been					
	assesseu.						
	Client #3's recor	d was reviewed on					
		P.M. A review of the					
	client's record fa	iled to indicate the					
	client's vocationa	al needs and abilities had					
	been assessed.						
	C1: 4 //4!	1 . 1					
		d was reviewed on P.M. A review of the					
		iled to indicate the					
		al needs and abilities had					
	been assessed.	WI 110000 WIIW WO 1111100 11WW					
	The Day Program	n Home Manager					
	· ·	erviewed on 3/8/13 at					
		DPHM indicated client					
		4's vocational needs and					
	abilities had not	been assessed.					
	9-3-4(a)						
	, , , (u)						

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	F OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 15G593	(X2) MULTIPLE CO A. BUILDING B. WING	00	CO!	TE SURVEY MPLETED 15/2013
NAME OF PI	ROVIDER OR SUPPLIEI	R	3142 62	ADDRESS, CITY, STATE, 2 2ND PL E RT, IN 46342	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TON SHOULD BE	(X5) COMPLETION DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	IA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		15G593	B. WIN			03/15/	2013
NAME OF D	ROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					2ND PL E		
	IANA INC				RT, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION DATE
W000249	483.440(d)(1)	LSC IDENTIFYING INFORMATION)	-	TAG	DLI ICILIACI)		DATE
	formulated a clier each client must r treatment prograr	EMENTATION terdisciplinary team has nt's individual program plan, receive a continuous active n consisting of needed services in sufficient					
	number and frequachievement of the the individual programme.	uency to support the ne objectives identified in gram plan.	III/0	00240			04/12/2012
		ation, record review and	WO	00249	The facility currently trains staf upon hire and annually on the	T .	04/13/2013
		cility failed to implement			importance of active treatment		
		es during times of			and how to implement the goa		
		of 4 sampled clients and			of the clients. The PD will retra		
		nt (clients #1, #2, #3, #4			staff on active treatment and h	OW	
	and #7). Findings include	:			to implement the goals of the clients. The PD will retrain staf on active treatment and appropriate times to implemen the goals of the clients. The	t	
	A morning obser	vation was conducted at			Home Manager will check daily	y	
	the group home	on 2/19/13 from 6:15			that the goals are being implemented and documented		
	A.M. until 8:00	AM. At 6:30 A.M.,			The Program Director will chec		
	Direct Support P	rofessional (DSP) #1			monthly that the goals are beir		
	administered clie	ent #3's prescribed			implemented and documented		
	medication. Clie	ent #3 did not learn about			appropriately. If for any reason goals are not successful or do		
	his medications.	At 6:44 A.M., DSP #1			meet the clients needs. The te		
	administered clie	ent #7's prescribed			will meet along with the client t		
	medications. Cli	ient #7 did not learn			determine appropriate goal		
	about his medica	tions and did not punch			choices. The home facility		
	out his medication	ons. During the			Program Director will retrain th Day service Manager and staff		
	observation perio	od clients #2, #3 and #4			active treatment and	. 5	
	sat in the living r	oom unsupervised and			implementing the client goals		
	with no activity.	Client #1 stayed in his			formally and informally.		
	-	with no activity. DSP #1					
	administered me	dications and DSP #2					
	cooked breakfast	t while clients #2, #3 and					

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G593	B. WIN	G		03/15/2	2013
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			3142 62	ND PL E		
REM-IND	DIANA INC			HOBAR	T, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		sed and with no activity.					
		t and was not prompted to					
		ped eyeglasses during the					
	entire observation	on. There was no choice					
	of activities offe	red nor implementation					
	of clients' goals	during this observation					
	period.						
	A review of clien	nt #1's record was					
	conducted on 2/2	22/13 at 11:30 A.M. The					
	Individual Progr	am Plan (IPP) dated					
	5/12/11 indicated: "Will wear his glasses						
	more with staff a	assistanceWill sit down					
	with staff and so	rt out his petty cash					
		ominationsCooking,					
	_	place settingwill					
		dependent with cleaning					
		l increase his self					
		s by holding his med					
	_	s by nording his med					
	cup."						
	A ravious of alia	nt #2's record was					
		22/13 at 11:55 A.M. A					
		#2's ISP dated 10/2/12					
	indicated: "Will	-					
		ill sort out any cash that					
		shwill set the kitchen					
	_	cipate in a physical					
	activity."						
	A review of clies	nt #3's record was					
		22/13 at 1:55 P.M. The					
		2 indicated: "Will learn					
	about his medica	ationsWill increase his					

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	of correction (X1) provider/supplier/clia (DENTIFICATION NUMBER: 15G593	(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 15/2013	
	PROVIDER OR SUPPLIER DIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	physical activityWill reconcile his petty cashWill participate in household chores."					
	A review of client #4's record was conducted on 2/27/13 at 1:24 P.M. The ISP dated 7/30/12 indicated: "Will punch out her medicationsWill count her petty cashWill walk dailyWill participate in household chores."					
	A review of client #7's record was conducted on 2/27/13 at 10:55 A.M. The ISP dated 1/22/13 indicated: "Will punch out his medicationsWill count her petty cashWill walk dailyWill participate in household chores."					
	The Program Director (PD) was interviewed on 3/8/13 at 1:30 P.M. The PD indicated active treatment should be ongoing and training should be both formal and informal. She further indicated there should be enough staff present to carry out the training objectives. 9-3-4(a)					

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		IDENTIFICATION NUMBER: 15G593	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI 03/1	E SURVEY PLETED 5/2013		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP PND PL E	CODE			
REM-IND	DIANA INC		HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		

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STATEMEN	T OF DEFICIENCIES	DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE			E CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		15G593	B. WIN			03/15/	2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				2ND PL E		
REM-IND	IANA INC				RT, IN 46342		
(X4) ID	STIMMADVS	TATEMENT OF DEFICIENCIES		ID	<u> </u>		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
W000262	483.440(f)(3)(i)						
***************************************		IITORING & CHANGE					
		nould review, approve, and					
	monitor individual	programs designed to					
		riate behavior and other					
		the opinion of the					
	committee, involv and rights.	e risks to client protection					
	Based on record	review and interview, the	W0	00262	The facility is committed to		04/13/2013
	facility failed for	3 of 3 clients who			making sure that the clients		
	needed revisions	to their Behavior			health and safety is maintained		
	Support Plans (BSPs) due to elopement from the group home and physical aggression (clients #1, #3 and #7) to				all times. The Program Director trained during supervisiory	r IS	
					training on the role of The Hun	nan	
					Right's Committee and how of		
	'	n Rights Committee			they should be meeting regard	ling	
		provals at a time when			the clients medication and		
		resent or able to have			program changes. The Progra Director will be retrained on th		
	_	rding the approvals of			process by the Area Director.		
	_	rung the approvals of			Program Director will make su		
	BSPs.				that the Human Right's		
	Findings include				Committee meet as needed		
	Findings include	•			based on the needs of the clie and how quickly the changes	nτ	
	A review of clies	nt #1's record was			need to be implemented		
		22/13 at 11:30 A.M.			according to their health and		
		#1's record indicated a			safety. During this time the Program Director will have har	nd	
		2 addressed to each of			written notes taken by the	iu	
					designated Human Rights		
	•	C members indicating:			Member and copies given to the	ne	
	"Dear Human Ri	~			team to keep track of what wa	S	
		disciplinary Team: This			discussed by the Program		
	_	ls to [client #1]. [Client			Director. The Program Directo	r	
	#1's] behaviors h	nave continued and			will be retrained by the Area Director that formal notices		
	increased physic	ally aggressive			should be sent to all team		
	occurrences. [D	octor name] has			members in a timely fashion a	nd	
	prescribed [clien	-			that no changes will be		
		g (milligram) tablet orally			implemented until the committ		
	(5 (<u>6</u>)0144 01411			has met and agreed to what is		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G593		A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 03/15/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE P.ND PL E P.T., IN 46342		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	(X5) COMPLETION
TAG	twice a day to he behavior. Your a before the above implemented. Pl whether you agree	pproval is required		TAG	needed to support the client in which we serve. In the future the Area Director will review the Ameeting notes to ensure all the HRC issues have been discussed approved by the HRC team. Responsible Party: Area	he HRC e ssed	DATE
	envelope. If you please feel free to A review of clier conducted on 2/2	have any questions			Director		
	letter dated 12/17 the facility's HRO "Dear Human Ri Committee/Inter-	7/12 addressed to each of C members indicating:					
	#3] has eloped to [Behavior Special a behavior support needs. We need to	vice from his residence. ulist name] has developed ort plan especially for his your your help inorder to lan to support [client					
	#3's] behaviors. required before t implemented. Pl whether you agree	Your approval is he above changes are ease indicate below se or disagree with the					
	envelope. If you please feel free to	the form in the attached have any questions o contact me."					
	conducted on 2/2 Review of client	#7's record was 2/13 at 4:30 P.M #7's record indicated a 2 addressed to each of					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 15/2013
	ROVIDER OR SUPPLIER		3142 62	ADDRESS, CITY, STATE, ZI 2ND PL E RT, IN 46342	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	"Dear Human Ra Committee/Inter- letter is in regard #7] has had incre- which include in- outbursts and off- name] prescribed Lorazepam 1 mg which will help a Your approval is above changes a indicate below we disagree with the form in the attachave any question contact me." An interview wi (PD) was conducted. P.M. The PD incommeetings/discusses the mentioned approved.	disciplinary Team: This disto [client #7]. [Client eased targeted behaviors ritability, temper her occurrences. [Doctor disciplinary] with g (milligram) twice daily, decrease these activities. It is required before the re implemented. Please whether you agree or echanges. Return the hed envelope. If you ons please feel free to the het program Director ceted on 3/8/13 at 1:30 dicated HRC sions were not held for opprovals. The PD further were sent out to all HRC				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	а віл	LDING	00	COMPLET	ΓED
		15G593	B. WIN			03/15/20	013
NAME OF B	DOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER			3142 62	2ND PL E		
	DIANA INC				RT, IN 46342		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re (COMPLETION DATE
W000268		LSC IDENTIFYING INFORMATION)	+	TAG	BEI ICILIACT)	+	DATE
VVUUU200	483.450(a)(1)(i) CONDUCT TOW	ARD CLIENT					
		d procedures must					
	promote the growth, development and						
	independence of						
		ation and interview, the	W0	00268	The facility is committed to	I	04/13/2013
	facility failed for	1 of 4 sampled clients			promoting the welfare and digr	nity	
	(client #3), to pro	omote his dignity by not			of the clients we serve. The facility is also committed to		
	ensuring he was	groomed.			maintaining the health and safe	etv	
					of all the clients we serve. The	-	
	Findings include	:			Program Director and the Home		
	_				Manager are trained during		
	A morning observation was conducted at the group home on 2/19/13 from 5:45				supervisory training that the facility is responsible to mainta	ain	
					all the needs of the clients we		
	• •	A.M During the entire			serve while they live in the faci	ility.	
		nt #3 was observed to			The Program Director and Hor		
		al hair. Client #3 had his			Manager will be retrained that	all	
	-	t and was unshaven.			the clients should receive hair cuts at and outside facility that	. will	
	nan ankepa anea	t and was unshaven.			be paid for by the facility. The	VVIII	
	A avaning obser	vation was conducted at			Program Director will do an		
	_	on 2/19/13 from 5:00			assessment on the client to		
		P.M During the entire			during the needs and supports		
		at #3 was observed to			needed while shaving. After the assessment is done a formal g		
		al hair. Client #3 had his			will be put in place to assist the		
	_	t and was unshaven.			client with shaving. The Progra	I	
	nan unkepuuncu	u anu was unsnaven.			Director will retrain staff on		
	An interest	-h aliant #2			assisting and making sure all clients are shaved appropriate	lv	
	An interview wit				in accordance to the need leve	•	
		group home on 2/26/13			the client. The staff will be		
		When asked when he			retrained by the Program Direct		
	_	r cut client #3 stated "I			to document on the formal goa		
	don't have no mo	oney to get my hair cut."			the level of progress being ma by the client. The Home Mana		
	An interview wit	th the Program Director			will monitor the client and	Ĭ	
		ewed on 3/8/13 at 1:30			documentation daily and week to make sure appropriate	ıy	
	` ′	ated client should be			grooming is taking place for the	e	
	1.11 111011081	area enem should be			J. Seriming to taking place for the	-	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	LDING	NSTRUCTION 00	(X3) DATE : COMPL 03/15/	ETED
	ROVIDER OR SUPPLIER		3142 62	ADDRESS, CITY, STATE, ZIP CODE 2ND PL E 1T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
TAG		s at least monthly and	TAG	client. The Program Director of monitor the client and documentation at least weekly and monthly to make sure appropriate grooming is taking place for the client we serve.	will y	DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	DINC	00	COMPL	ETED
		15G593	A. BUII B. WIN	LDING		03/15/	2013
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
DEM IND	IANA INC				2ND PL E RT, IN 46342		
KEWI-IIND				HUBAR	R1, IN 46342		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000323	483.460(a)(3)(i)						
	PHYSICIAN SER						
		provide or obtain annual					
		tions of each client that at a					
	and hearing.	s an evaluation of vision					
	•	marriage and intermitary tha	1 11/0	00323	The facility is as remaitted to		04/13/2013
		review and interview, the	WU	00323	The facility is committed to maintain the health and safety	of	04/13/2013
		3 of 4 sampled clients			the clients. The facility is	Oi	
	,	nd #4) to have follow up			responsible for making sure th	at	
	vision and hearing	ng exams as			all clients appointments are ma		
	recommended by	the physician.			and kept in a timely manner. The Home Manager, Program		
	Findings include			Director and Facility Nurse will			
					retrained by the Area Director		
	Δ review of clier	nt #1's record was			maintaining the clients health the making and keep all	Эу	
		22/13 at 11:30 A.M.			appointments.The Home		
					Manager, Program Director an	ıd	
		d indicated a most current			Facility Nurse will also be	-	
	_	on dated 1/13/10 which			retrained on following the		
	indicated: "Follo	ow up in three years to			physicans orders as prescribe		
	monitor hearing	status." Client #1's			on the medication form. If for a	iny	
	record did not co	ontain evidence he had a			reason appointments are		
	follow up in thre	e vears.			canceled the Home Manager v	VIII	
		- J			reschedule the appointment immediately so that client #1,2		
	Δ review of clien	nt #2's record was			and 4 is receiving the appropri		
		22/13 at 11:55 A.M.			care while in the facility. In the		
					future, the Home Manager will		
		d indicated a most current			meet with the nurse on at leas		
		dated 4/6/11 which			monthly basis to ensure the		
	indicated: "Retu	rn in one year." Clients			client's medical appointments	are	
	#2's most current	t hearing evaluation dated			scheduled and current.		
	1/6/10 indicated	"Return in three years."					
	Client #2's record						
		a follow up vision					
		ommended in one year					
		ave a follow up hearing					
	evaluation in thre	ee years as					

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	DF CORRECTION IDENTIFICATION NUMBER: 15G593	A. BUILDING B. WING	00	COMPLETED 03/15/2013			
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	recommended. A review of client #4's record was conducted on 2/27/13 at 1:24 P.M. Client #4's record indicated a most current annual physical dated 12/13/11. Client #4's record did not contain evidence she had an annual physical for the calendar year of 2012. The Registered Nurse (RN) was interviewed on 3/8/13 at 1:40 P.M. The RN indicated clients #1, #2 and #4 did not return to the physicians as recommended. 9-3-6(a)						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	(X2) MULTII A. BUILDING B. WING		00	(X3) DATE COMPL 03/15/	ETED
	PROVIDER OR SUPPLIER		P. W.	STREET A	ADDRESS, CITY, STATE, ZIP CODE 2ND PL E RT, IN 46342	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
W000331	services in accord Based on observation observation interview 1 of 4 at #3), the facility's reconcile medical Medication Adm (MAR) and Physical Findings include A morning observation observation of the group home of A.M. until 8:00 A.M. until 8:00 A.M. until 8:00 A.M. of client # indicated: "Fexod (milligram) table mouth daily at be packet had writter A.M." A review of the Machine of the Mac	provide clients with nursing dance with their needs. ation, record review and sampled clients (client nursing services failed to ation labels, the inistration Record sician Orders (POs).	W0	00331	The Nurse will be retrained by Area Director that all meds she package and labled appropriately prior to coming the pharmacy. If for any reason any medications is not labeled labeled inappropriately the Fa Nurse will contact the pharma and have this corrected immediately. Client #3 times a labels have been corrected of MAR and nasal spray bottle. Nurse will also be retrained by Area Director that the label match the medication administration record prior to administering medication. Stawill be retrained to compare the medication with the medication administration record during a medication pass. If for any rethere is a discripency with the labels and medication administration record staff she contact the Facility Nurse and Call Supervisor immediately finstructions. Responsible Part Area Director	from on dor acility accy and nother the young the ust staff of the ason expenses ould do not or	04/13/2013

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	OF CORRECTION IDENTIFICATION NUMBER: 15G593	A. BUILDING B. WING	00	COMPLETED 03/15/2013			
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	administered at 7 A.M. An interview with the facility's Registered Nurse (RN) was conducted on 2/20/13 at 12:45 P.M When asked who checked the MAR, PO and medication packages to ensure the directives for administration matched, the RN stated "I do and the pharmacy. It got over looked and I will call the pharmacy." 9-3-6(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DDIC	00	COMPL	ETED
		15G593	A. BUII B. WIN			03/15/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			2ND PL E		
REM-IND	DIANA INC				RT, IN 46342		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
TAG W000388	483.460(m)(1)(i) DRUG LABELING Labeling for drugs based on current principles and pra Based on observ interview, the fact sampled clients of medication admit have the medicat Findings include A morning observ the group home of A.M. until 8:00 of medications were Support Professi A.M. A nasal specifient #3's medic not contain clien instructions for a did not contain a A review of the b Administration F 2013 to February	s and biologicals must be ly accepted professional actices. ation, record review, and cility failed for 1 of 4 observed during morning inistration (client #3), to tion labeled. Exercise administration was conducted at on 2/19/13 from 6:15 A.M. Client #3's e administered by Direct onal (DSP) #1 at 6:30 oray bottle was taken from cation bin. The bottle did tt #3's name or administration. The bottle in pharmacy label.	WO	TAG 00388	The Facility Nurse will be retrained by the Area Director all medication should be packaged and labeled appropriately prior to coming fithe pharmacy. If for any reason any medication is not labeled alabled inappropriately the facilinurse will contact the pharmaci immediately and have this issuicorrected. Client #3 issue with the time and label has been corrected on the MAR and has spray bottle. The Facility Nurse will also be retrained by the Ard Director the label must match is medication administration recording to staff administering medication. Staff will be retrained by the facility nurse to company the medication with the medication administration record uring the medication pass. If any reason there is a discriper with the label and medication administration record staff sho contact the facility nurse and contact the f	that rom n or ty se ea the ord for n or uld	DATE 04/13/2013
		pionateNasal Spray 50 s)1 spray in each nostril			call supervisor for instructions.Responsible Party: Area Director		
	(RN) was conducted P.M. The RN income.	th the Registered Nurse cted on 2/20/13 at 12:45 dicated all medications narmacy label on them.					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G593	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP 03/18	LETED 5/2013		
REM-IND	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO T DEFICIENCY	CORRECTION ON SHOULD BE THE APPROPRIATE Y)	(X5) COMPLETION DATE		
	9-3-6(a)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
	15G593			A. BUILDING B. WING			03/15/2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
REM-INDIANA INC					2ND PL E			
KEW-IND	MANA INC			пован	RT, IN 46342			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE	
W000436	483.470(g)(2) SPACE AND EQUIPMENT							
	The facility must f	furnish, maintain in good						
	repair, and teach	clients to use and to make						
	informed choices about the use of dentures,							
	eyeglasses, hear							
		aids, braces, and other						
		by the interdisciplinary						
	team as needed b	-	1170	00.42.6			04/12/2012	
		ation, record review and	WO	00436	The facility is committed to	•	04/13/2013	
		of 4 sampled clients who			maintaing the health and safet the clients. The Program Direct			
	wore eyeglasses	(client #1), the facility			and Home Manager will be	ioi		
	failed to encoura	ge and teach client #1 to			retrained by the Area Director	on		
	wear his eye glas	sses.			providing and maintaining the			
	Findings include				clients glasses, dentures and a	any		
					other adaptive equipment the			
					client requires. The Program			
	A				Director will do an assessment			
	•	rvation was conducted at			the client to determine what le	vei		
	• •	on 2/19/13 from 5:45			of support the client needs in order to maintain all adaptive			
	A.M. until 8:00	A.M. During the entire			equipment. The Program Direct	ctor		
	observation perio	od client #1 did not wear			will then put a formal goal in pl			
	his prescribed ey	eglasses. Client #1 was			to support the client and			
	not prompted by	staff to wear his			document progress made by the			
	eyeglasses.				client. The Program Director w	rill		
	An evening observation was conducted at the group home on 2/19/13 from 5:00				retrain staff on the goal and			
					documentation of the goal. The	е		
					Program Director will provide and train the Day service			
	0 1				Manager and staff on all adapt	tive		
		P.M During the entire			equipment and the goals put in			
	•	od client #1 did not wear			place in order to document			
	his prescribed ey	veglasses. Client #1 was			progress or additional support			
	not prompted by	staff to wear his			needed by the client. The Day			
	prescribed eyegl	asses.			service manager will implemen	nt		
	_ , ,				the goals for the clients for			
	A facility owned	l day program observation			additional training will at day			
	•				program. In the future the Program Director and Home			
		n 3/8/13 from 10:00			Manager will do an active			
	A.M. until 1:00 l	P.M. Client #1 was			I wanaga wiii ao an active		l l	

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	of Correction identification number: 15G593	(X2) MULTIPLE CO A. BUILDING B. WING	00	03/15	LETED 5/2013		
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	observed during the entire observation period not wearing eye glasses. Client #1 was not prompted by staff to wear his prescribed eyeglasses.		treatment observation fo to monitor progress.Res Party: Area Director				
	A review of client #1's record was conducted on 2/22/13 at 11:30 A.M. Review of client #1's most current vision exam dated 3/14/12 indicated: "Patient to wear glassesprescription for Nystagmus." An interview with the nurse was conducted at the facility's administrative office on 3/8/13 at 1:40 P.M. The nurse indicated client #1 wore eyeglasses. When asked if staff should encourage and teach client #1 to wear his prescribed eyeglasses, the nurse stated "Yes." 9-3-7(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED 03/15/2013		
15G593		B. WING			03/15/	2013	
NAME OF P	ROVIDER OR SUPPLIER	_		STREET .	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF FROVIDER OR SUFFLIER					2ND PL E		
REM-INDIANA INC				HOBAF	RT, IN 46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W009999							
	State Findings		W0	09999	The facility is committed to		04/13/2013
					making sure that all policies a	nd	
	The following C	ommunity Residential			prodecures are being met		
	_	sons with Developmental			according to state guidelines.		
		_			Program Director is trained du supervisiory training that all th		
	Disabilities rule was not met.				client are required to have a		
	460 IAC 9-3-4 A	ativa Treatment			meaningful day and should be	,	
		cuve Treatment			participating in some form of		
	Services.				vocational training whether that		
	(b) The provider shall obtain day services for each resident which: (1) meet the criteria and certification requirements				be through volunteer, paid wo		
					or a sheltered workshop. Upo		
					admission of the client there a several assessments done to	re	
	established by the division of aging and				determine the level of needs,		
	rehabilitative services for all day service				supports and vocational training	na	
	providers; (2) meet the resident's active				the client would like to pursue	-	
	treatment needs set forth in the resident's				The Program Director will be		
					retrained by The Area Director		
	individual program plan as determined by				this process to make sure it is		
	•	ary team conference with			implemented immediately. The	е	
	preference for services in the least restrictive environment. This state rule was not met as evidenced by: Based on observation, record review and interview, the facility failed to meet the active treatment needs pertaining to day services programming for 1 of 4 sampled				Program Director will also be retrained by the Area Director	that	
					regular team meetings are hel		
					make sure that the process f t		
					client entering a day program		
					happening immediately. If for		
					reason there are any set back		
					to why the client is not in a day	У	
					program setting an activity schedule will be put in place for		
					the client to be active in the	וכ	
					community while waiting for da	av I	
					placement. Aslo during this tin		
	clients (client #3).			a team meeting should be held		
					needed by the Program Direct		
	Findings include	:			in order to meet the clients ne		
	Client #3 was observed at the group hor				regarding community inclusion	ו	
					and a meaningful day.Responsible Party: Area		
		- •			day.responsible raity. Alea		

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		IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION . DUE DIEG 00			(X3) DATE SURVEY COMPLETED	
15G593			LDING		03/15/		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					2ND PL E		
REM-IND	DIANA INC			HOBAR	RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TE.	COMPLETION
TAG		10:00 A.M. until 12:24		TAG	Director		DATE
		e observation client #3 sat			Birector		
	1	n and watched television.					
	~	ay service was observed					
	to be provided.	ay sorvice was observed					
	Page 1						
	Client #3 was ob	served at the group home					
	on 2/22/13 from	10:00 A.M. until 2:30					
	P.M. During the	e observation client #3 sat					
	_	n and watched television.					
	No alternative day service was observed						
	to be provided.						
	Client #2 was absorbed at the success because						
	Client #3 was observed at the group home on 2/26/13 from 9:45 A.M. until 11:30						
	A.M. During the observation client #3 sat						
	in the living room and watched television.						
	~	ay service was observed					
	to be provided.						
	_						
	Client #3's recor	ds were reviewed on					
	2/22/13 at 1:55 P.M. A review of the						
	client's record failed to indicate he						
	attended day service.						
	An into	th the Crown Home					
		th the Group Home) was conducted on					
	2/22/13 at 12:20						
		#3 had not attended day					
		s admission on 10/1/12.					
		er indicated the facility					
		ss of having him attend					
	day services.	<i>5</i>					
	l .						ı

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	COMPL		
15G593		A. BUILDING B. WING			03/15/2013			
NAME OF I	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE	•		
REM-INDIANA INC			3142 62ND PL E HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE	
	PD indicated the acclimate client services program #3's present day and certification by the Division of Rehabilitative Se	/8/13 at 1:30 P.M. The facility is working to #3 to an outside day n. When asked if client activities met the criteria requirements established						

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